

Lifeline Hull Recovery Service

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following areas of good practice:

- Staff were caring and non-judgemental. Clients felt supported and were able to be honest and open with staff about their problems. Staff encouraged clients to progress in their recovery and promoted improved social functioning.
- Staff saw clients for assessment within national targets. They were given flexibility in appointments

and the location they wished to attend. The service was improving its programme for group activities. Clients were involved in their recovery plans which were regularly reviewed.

- Staff reviewed risks regularly and took actions to manage identified risks. This included regular harm minimisation advice, the availability of safe storage boxes, providing naloxone kits to those at risk of opiate overdose and a discreet needle exchange for those with high risk injecting behaviours.

Summary of findings

- Staff knew when and how to report incidents. Staff provided clients and families with information on how to complain. Staff shared lessons learned from incidents and complaints in team meetings and supervision sessions.

However, we also found the following issues that the service provider needs to improve:

- The service did not effectively monitor and review training. It was unclear which training units staff were expected to complete as mandatory. It was also unclear how often staff were required to refresh their training. The training figures provided during the inspection showed low completions in many units.

This included mental capacity act awareness. Staff mostly joined the organisation with prior training in the delivery of psychosocial interventions. However, the service did not ensure they remained up to date.

- Recovery plans were unstructured and did not prompt staff to consider specific domains. This meant that identified needs were not always included as needed.
- Staff did not fully explore a client's physical health needs.
- There was limited space for both staff and clients at the Octagon.

Summary of findings

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Summary of this inspection

Background to Lifeline Hull Recovery Service

Lifeline is a registered charity and a national provider of drug and alcohol services. Established in 1971, the organisation has CQC registered services across England.

In 2014, Hull City Council commissioned a group of organisations to provide a drug and alcohol treatment and support system under the umbrella brand name ReNew. As part of this system, the local authority awarded Lifeline two contracts to provide community services for adults with substance misuse problems. This included the delivery of the following elements across the two contracts:

- Early interventions.
- Harm minimisation.
- Specialist prescribing including community detoxification.
- Care co-ordination.
- Psychosocial interventions including counselling.
- Long term in treatment.
- Through care and aftercare.

- A discreet needle-exchange service for clients identified as at risk.
- Family and carer work.

The Hull Lifeline provision operates from three sites:

- The Octagon, covering central Hull and accessible from the main transport links.
- Bransholme, covering North Hull.
- Gypsyville, covering West Hull.

At the time of our inspection, the service was working with approximately 1400 clients.

Due to management changes, at the time of this inspection, Lifeline was in the process of registering a new CQC manager for Hull. In the interim, the organisation's responsible CQC person and a registered manager from elsewhere in the same directorate were covering this role. The service was registered with the CQC to provide the following regulated activities:

- Treatment of disease, disorder or injury.

CQC have not inspected this service previously.

Our inspection team

The team that inspected the service comprised CQC inspector Christine Barker (inspection lead), one CQC inspection manager, one other CQC inspector and a specialist advisor in substance misuse.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Summary of this inspection

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location and asked other organisations for information.

During the inspection visit, the inspection team:

- visited all three sites, looked at the quality of the physical environment, and observed how staff were caring for clients

- spoke with 13 clients
- spoke with the interim manager
- spoke with 18 other staff members employed by the service provider, including the lead clinician, nurses and recovery workers
- spoke with two carers
- attended and observed three daily meetings, an assessment, two clinical appointments, two team meetings and one client group
- looked at 12 care and treatment records, including medicines records, for clients
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with 13 clients using the service and two carers. All told us that the staff were supportive, approachable and treated them with respect. They said that there was good access to appointments and that staff discussed choices about their treatment options. One client told us that they were able to say things to their worker that they had previously found difficult to share. Another told us that the service had opened their mind up to the possibility of recovery.

All clients spoke positively about the service and the environment. However, three clients also informed us that it was sometimes difficult to get through on the telephone and they had to leave messages on the service's answerphone that did not always get through to their keyworker.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- The service did not specify which training units staff were required to complete as a mandatory requirement. It was also unclear how regularly staff should refresh their training. Staff training levels were low in the units that were provided by the organisation.

However, we also found the following areas of good practice:

- Premises were clean, tidy and well maintained and each location had a well-equipped clinic room.
- Staff assessed risks regularly and took appropriate actions to manage identified risks.
- Staff knew what constituted an incident and how to report it.

Are services effective?

We found the following areas of good practice:

- Staff completed comprehensive assessments of clients' needs in a timely manner.
- Recovery plans were personalised and holistic.
- Clients received care and treatment underpinned by best practice.
- Staff from the service promoted recovery and encouraged
- The staff team included a good range of disciplines required to care for the client group.
- Staff attended effective daily meetings to remain up to date with daily occurrences and incidents.

However, we also found the following issues that the service provider needs to improve:

- Staff did not always reflect all identified needs in a client's recovery plan.
- Staff did not fully explore a client's physical healthcare needs.
- The service did not ensure staff remained refreshed and up to date with knowledge relating to psychosocial interventions.
- Staff had not received training on the Mental Capacity Act.

Are services caring?

We found the following areas of good practice:

Summary of this inspection

- Staff supported clients with a respectful and non-judgemental manner.
- Staff maintained client's confidentiality and only shared information where this had been agreed.
- Clients were actively involved in their recovery plans and were encouraged to progress in their recovery.
- The service included a family team to support a client's family and help increase client motivation.

Are services responsive?

We found the following areas of good practice:

- Client waiting times from referral to assessment were, on average, below the national target of three weeks.
- The service had introduced a pro-active engagement pathway to reduce the number of unplanned discharges from the service.
- Staff from the service visited hostels to encourage the homeless population to engage and remain in treatment.
- Clients had flexibility in their appointment times and the location they wished their treatment to occur.

However, we also found the following issues that the service provider needs to improve:

- The Octagon had limited room availability for client appointments and rooms did not promote a recovery-focussed atmosphere.

Are services well-led?

We found the following areas of good practice:

- Staff had opportunities to give feedback on the service and felt able to raise concerns without fear of victimisation.
- The service reported into a central governance system and had processes in place to monitor performance, staffing, incidents and complaints.
- Staff felt supported by their colleagues and team leaders and morale was improving following a period of uncertainty.

However, we also found the following issues that the service provider needs to improve:

- The service did not effectively monitor staff training.
- Some staff working at the Octagon found the working environment stressful due limited office space.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

There was no evidence of staff receiving Mental Capacity Act awareness training. However, staff were knowledgeable in the act and knew to refer any concerns to their manager. The organisation had a Mental Capacity Act policy which staff could refer to if required.

All records we looked at showed that clients had consented to their treatment and confidentiality had been discussed. We saw evidence of signed information sharing agreements allowing staff to share specific information with the agreement of the client.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

Staff mostly saw clients at the service's location sites at the Octagon, Bransholme and Gypsyville. All the environments were clean, tidy and well maintained. Cleaning records demonstrated that domestic staff cleaned the premises regularly.

Both staff and clients told us they felt safe at the service. Interview rooms were fitted with alarms. Each site had up to date and available health and safety assessments and fire risk assessments. The staff rota identified the day's fire wardens and first aiders.

Each location had a well-equipped clinic room. They contained the necessary equipment to carry out examinations, this included handwashing facilities, weighing scales, electrocardiograph machines, and blood pressure monitors. General equipment was in good condition and portable appliance testing had been carried out where necessary. Staff ensured necessary calibration checks were up to date. Locations had emergency first aid boxes and resuscitation equipment. They also kept adrenaline for anaphylactic shock or cardiac arrest and naloxone to reverse the effects of an opiate overdose. Staff checked equipment on a monthly basis and stored the adrenaline and naloxone appropriately.

We observed that staff adhered to infection control principles. Anti-bacterial hand washing gels were located around the buildings and clinical staff had access to personal protective equipment such as aprons and gloves for carrying out examinations. Clinical team meeting minutes evidenced that staff discussed infection control regularly. Each location had a contract for the collection of hazardous waste by a licensed provider.

Safe staffing

The service determined staffing levels with reference to the contract specified by commissioners. Staff, clients and carers all felt staffing levels were adequate. Staff rarely cancelled appointments and clients had regular one to one time with a recovery worker.

There were 93 staff positions in total for the service. This included 58 frontline substance misuse staff. Roles additional to this included clinicians, team leaders, senior practitioners and managers. The service also had the additional resource of 11 active volunteers. At the time of our inspection, there was a vacancy for the service manager, two outreach workers, one early intervention worker, one recovery coordinator and one non-medical prescriber. Lifeline had appointed a new GP and was awaiting a start date. The service manager's position was in the recruitment phase. There was also three staff on long term sick.

The organisation seconded 1.5 full time staff from other services in the same Lifeline directorate to ensure the service met the clients' needs. Staff were mostly able to cover appointments within the teams for unexpected sickness. They only rescheduled appointments if there was no significant risk.

The service had two non-medical prescriber positions. At the time of our inspection, one of these roles was filled by agency staff.

Caseloads were between 50 to 60 clients for each worker depending on the interventions required. Managers did not use a caseload weighting tool, but took into account the complexities of each client and could re-allocate them amongst the team if needed. Team leaders regularly reviewed caseloads as part of the supervision process.

The Lifeline organisation offered some training to ensure staff competence to carry out their roles. This comprised of face-to-face learning sessions and e-learning. However, the organisation did not identify which units were mandatory.

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Additionally, Lifeline did not specify a compliance target for services to achieve. The CQC would expect providers to achieve a minimum of 75% compliance for staff completion of mandatory training units. This meant that managers had no guidelines to ensure staff received the relevant training and refresher training as and when required. The service was below 75% compliant in the following units (these figures include staff who were on long term sick, maternity leave or in their probationary period):

- Basic Life Support 0%.
- Health and Safety 6%.
- Confidentiality and Information Sharing 14%.
- Data Protection 48%.
- Drug Awareness 62%.
- Boundaries 68%.
- Alcohol Awareness 69%.
- Risk Management 70%.
- Safeguarding Adults e-learning 72%.
- Safeguarding Children e-learning 72%.
- Accessible Information Standards 74%.

Lifeline had introduced new e-learning units in manual handling, equality and diversity, health and safety, first aid and infection control. At the time of our inspection, no members of staff had completed this training.

Staff from the service were required to deliver psychosocial interventions. The organisation had training available in these interventions including motivational interviewing, cognitive behavioural therapy, link mapping and brief solution focused therapy. Staff compliance in this training was all below 40%. Managers told us that staff had received this learning prior to their employment with Lifeline.

Assessing and managing risk to clients and staff

Staff carried out risk assessments of the clients when they entered into treatment. Risks considered included the clients substance misuse, injecting behaviours, blood borne viruses, physical health, mental health, driving, dependants, criminal activity and social risks such as homelessness and debt. They reviewed these every 12

weeks, or more frequently if the client's circumstances changed. Risk assessments were located on the service's electronic system for all staff to access. The system alerted staff when the assessment was due for review.

From the 12 client records we looked at, 11 contained a risk assessment. Ten of these were up to date; one was eight months old. Assessments were mostly detailed. However, one assessment had incomplete sections. The electronic system colour rated risk severity to produce an easily accessible overview visible throughout the client's complete electronic record.

One client did not have a risk assessment in place. Staff notes detailed problems engaging this client into treatment. However, there was evidence in the client's detailed notes that noted a history of domestic violence, homelessness and previous suicidal ideations. It was therefore unclear whether other staff would be aware of these risks or what actions they were taking to manage them.

Staff included clear plans to manage all identified risks. These included harm minimisation advice and liaising and referrals to other professionals.

The service issued naloxone kits for clients at high risk of opiate overdose. Naloxone is an injectable medicine that reverses the effects of an opiate induced overdose. Staff provided training to clients and their carers for all kits offered. They also provided kits to hostels along with training. In the three months prior to our inspection, the service had issued kits to 21 service users and to 58 community based hostel staff. Since delivering the training, the service had received three confirmed uses of the kits within the community that had saved lives.

Naloxone kits were safely stored at the service and were all in date. The service did not store or dispense other medications prescribed by staff. Local pharmacies dispensed the client's prescription.

Staff considered the risks of clients when prescribing substitute medications for a person's opiate use. A client would initially start on a supervised prescribing regime where it was necessary to take their medications on a daily basis at their pharmacy. This meant someone else could not either intentionally or accidentally consume the client's medication. For example, the client selling on their medication to other substance misusers or a child accidentally consuming the medication. Staff monitored

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these risks relating to the diversion of medication by liaising regularly with the pharmacies, by regular keyworker sessions and by conducting urine screens. The clinician reviewed the client's risks at each appointment to consider if it was safe for the client to take their medication away from the pharmacy for consumption at home. The service issued out safety boxes for clients with children. This gave the client a lockable place to store their medication at home to prevent access by a child. We saw evidence in client's records that staff discussed the safe storage of medications in the home.

The service was not commissioned to provide a community needle exchange. However, clients had access to emergency packs containing clean drug using paraphernalia. Staff offered these discreetly to those clients identified as high risk due to their unsafe injecting behaviours, for example using previously used needles. For all injecting clients, staff discussed safer injecting practices to reduce harm.

The service had a safeguarding lead and a safeguarding policy. Staff we spoke to were aware of what constituted a safeguarding concern and the action they would take. The service had made 12 referrals to the local safeguarding authority in the six months prior to our inspection. The manager told us that they expected staff to complete the e-learning safeguarding training units as a minimum. Compliance was at 72% for both safeguarding adults and safeguarding children. The service aimed to reduce the number of safeguarding referrals by involving their family team with all clients where staff identified children in the household or social care involvement. The team worked alongside the client's key worker to reiterate key safety messages and the effects of treatment on the whole family.

Track record on safety

The provider has stated that there were no serious incidents requiring investigation that occurred 12 months prior to our inspection.

The service contributed to two serious case reviews led by Hull's Community Safety Partnership to consider any shared learning. They also received a six-monthly summary from the courts and tribunals judiciary. This publication provides a summary of five recommendations from local coroners with the intention of learning lessons from the cause of death and preventing future deaths. There were no concerns relating to Hull Lifeline in recent reports.

Reporting incidents and learning from when things go wrong

Staff knew what constituted an incident and how to report it. They told us the reporting system was easy to use. All reported incidents fed into an organisational governance process to identify themes for future learning. Managers discussed incidents at a local level. The organisation's clinical governance lead reviewed incidents that were more serious. Operations managers and team leaders carried out investigations across the Lifeline organisation.

We observed managers and clinical meeting minutes, which included incident discussions, and in the daily team meeting. Managers and team leaders disseminated lessons learnt from the incidents in these meetings and in supervisions and team meetings.

Duty of candour

The duty of candour is a legal duty on providers to inform and apologise to clients if there have been mistakes in their care that have led, or could lead, to significant harm. The service had a duty of candour policy and managers were aware of their responsibilities under this. The staff team took ownership of their actions and promoted an ethos of openness and transparency. Staff informed us of an example where the policy had been used. This related to staff sending a client letter to a wrong address.

Are substance misuse services effective? (for example, treatment is effective)

Assessment of needs and planning of care

Referrals into the service came through a single point of contact. Staff considered the initial information received to decide whether structured treatment was appropriate or whether brief interventions alone could meet the client's needs. This would depend on the person's drug use and their risks. Staff carried out comprehensive assessments within two weeks from referral for those clients requiring more structured interventions. The assessment considered a client drug use, physical health, mental health, housing, finances, blood borne viruses, previous treatment experiences, cultural beliefs, education, employment, criminal activity and other social needs. Staff discussed

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with clients their expectations and their individual strengths and barriers that could affect this. The family team also explored children's safety, education, well-being and health.

We looked at 12 client records. All contained an assessment. These were mostly comprehensively completed. However, four records showed limited exploration into a client's historic drug use and previous treatment experiences.

Following assessment, clients agreed recovery plans with staff. Lifeline required staff to review clients' recovery plans at least 12 weekly. Of the 12 client records we looked at, 11 clients had recovery plans. Two of these were out of date at five and eight months old. One client had no recovery plan. Recovery plans were mostly personalised and containing holistic objectives. They were recovery orientated and included goals towards eventual discharge from the service. However, the care plans the service used did not prompt staff to consider recovery goals in specific domains, for example, drug use, health, social functioning or criminal activity. This meant that staff did not always reflect assessment and progress notes as goals in the recovery plan. For example, one client's progress notes documented adulterated urine screens and visible injection marks. Adulterated urine screens are when a client interferes with a specimen to give a false reading. However, the recovery plan did not specify goals relating to drug use or injecting behaviours.

All care records were securely stored on the organisations electronic system. This was readily accessible to all authorised staff as needed.

Best practice in treatment and care

We observed reference to best practice guidance in client records, meetings and client appointments.

The service prescribed medications as recommended by the Department of Health's UK Guidelines on Clinical Management for Drug Misuse and Dependence. Clinicians conducted face-to-face appointments for clients starting a prescribing regime. Staff screened for drug use routinely throughout treatment and nurses carried out recommended tests for those clients on high doses of methadone. For example, electrocardiograms for clients

prescribed over 100ml of methadone. Service policies around opioid detoxification and aftercare prescribing also referred to National Institute of Health and Care Excellence clinical guideline 52 for opioid detoxification (2007).

Records observed mostly evidenced the rationale around prescribing decisions. For example, reasons for increases or decreases in medication or reasons for changes from methadone to buprenorphine. However, one record showed an increase in medication with no explanation in clinical or progress notes. This made it unclear how prescribing took into account personal circumstances alongside guidance for this client.

The department of health's guidance states that treatment for drug misuse should always involve a psychosocial component. Staff told us they used a 'toolbox' of interventions in one to one sessions with clients. These included interventions recommended by the National Institute for Health and Care Excellence including cognitive behavioural therapy, motivational interviewing and solution-focused therapy. The service had a programme of group work in place. They were introducing additional elements to increase the psychosocial offer however this was still in its infancy. Clients told us attendance was still quite low for some groups.

Staff used node link maps. Node link mapping is a technique recommended in Public Health England's "Routes to Recovery" guide. It is a simple way for presenting verbal information in the form of a diagram that has positive benefits for key working. Some records contained mapping tools in the assessment records, for example, 'My strengths', however, these had not been completed.

The Strang Report 2012 (commissioned by the National Treatment Agency) details the need for treatment providers to focus on recovery rather than maintenance on medication. The report detailed that recovery is best defined by factors other than medication status and hinges on broader achievements in health and social functioning. The client records we looked at evidenced goals and interventions relating to recovery beyond medication. Staff discussed and planned medication reductions with clients. Interventions included goals to build the client's recovery capital and detailed aspirations for a client's discharge from treatment with improved health and wellbeing. Recovery capital refers to the internal and external resources necessary which a client can draw upon to achieve and

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maintain recovery from substance misuse as well as make behavioural changes. Lifeline provided information on a range of holistic activities to engage clients in treatment and promote recovery. Clients we spoke to were aware of the range of services and activities available.

The service used peer mentors where appropriate as recommended by Strang to make the possibility of recovery visible.

Both The National Institute for Health and Care Excellence guidance and the Strang report recommend that clients have access to mutual aid support groups such as alcoholics anonymous and narcotics anonymous. Mutual aid is typically treatment that occurs outside formal treatment settings and offers locally derived peer support networks. The service facilitated recovery groups from the Octagon and signposted clients to other groups in the community.

Staff did not fully consider physical health needs. Eight of the 12 records we looked at included some details of physical healthcare. Staff asked one question during assessment relating to physical health. It was therefore reliant on their skills to explore any concerns to ensure their safe and effective treatment. Staff contacted the client's GP if the client was receiving clinical interventions.

Lifeline were able to monitor the performance of their individual services at a national level and against other providers. Staff completed periodic treatment outcome profiles for the clients. This information reports into the National Drug Treatment Monitoring Service. The National Drug Treatment Monitoring Service collects, collates and analyses information from and for those involved in the drug treatment sector. Public Health England manages the National Drug Treatment Monitoring Service; producing activity reports for providers to give a full picture of activity nationally.

The Lifeline organisation had a framework for services to complete audits at local and national levels. The service had carried out recent audits on carer's needs, supervised consumption, deaths in service, clients on buprenorphine and an audit on clients not attending. This meant the service could identify improvements to services. For example, we saw how the service had introduced a new engagement pathway following an audit on client attendance.

Skilled staff to deliver care

The staff team included a full range of disciplines to care for the client group. This included team leaders, senior practitioners, clinicians, non-medical prescribers, a dual diagnosis nurse, a counsellor, a housing support worker, an information and resource officer, administrators and peer mentors.

Staff felt the induction they received to their role was adequate. New staff spent time with different members of the team. The service recruited staff against role-specific job descriptions, which set out the required competencies for each role. Managers assessed competency before completion of probationary periods. Staff then put personalised plans in place for continuing professional development, which team leaders monitored through annual appraisals. Staff were able to identify specific training required for their role. Lifeline supported this where possible.

The organisation did not set any requirement for staff to complete regular training in psychosocial interventions. The Federation of Drugs and Alcohol Professionals recommend key areas of learning to underpin the treatment and support provided to substance misuse clients, this includes psychosocial interventions. The majority of staff had received training in these interventions through previous employment prior to joining the Lifeline organisation at contract commencement in 2014 or afterwards. However, the service did not ensure staff remained updated and refreshed in these skills. This meant that managers could not be assured that staff were competent in providing the necessary knowledge and skills to provide these interventions.

Staff told us they received regular supervision and a yearly appraisal. Staff compliance with supervision was at 77% at the time of our inspection and 86% of staff had received an appraisal within the previous year. Non-medical prescribers received supervision from the clinical lead in addition to line management supervision. Team leaders also observed their staff conducting at least two client one to one sessions per year to support and develop staff to provide good standards of care and treatment.

The service held regular team meetings within smaller teams to cascade information and support staff. Agenda items included diversity, safeguarding, upcoming events, staffing and training.

Multidisciplinary and inter-agency team work

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The service had recently introduced daily brief meetings. Staff at all locations attended the meetings that lasted approximately 15 minutes each morning. The meetings discussed staff issues, the day's activities, incidents from the previous day, training and any key concerns about clients. Staff spoke positively about the introduction of the meetings. Staff attendance was high and team leaders delivered the information in a clear and concise manner.

We observed a collaborative approach between the clinical team and recovery workers. This provided the client with a united treatment approach focusing on both clinical care and psychosocial considerations.

The clinical team had good working links with the pharmacies used by clients. The lead for the local pharmacies attended Lifeline's clinical meetings to represent all pharmacies.

Staff attended Hull Royal Infirmary each morning to identify patients that may benefit from attending the service for drug or alcohol treatment. They also provided training to the ambulance service and homeless organisation regarding new psychoactive substances.

The family team attended meetings led by Hull City Council regarding early help for families. Staff met with health visitors and school nurses and routinely attended multi-agency risk assessment conferences.

The service had good links with local hostels and refuges for people with domestic violence concerns.

Good practice in applying the MCA

Mental Capacity Act awareness training was available from the organisation as an e-learning package. Managers were unable to provide figures to show staff compliance. The organisation had a Mental Capacity Act policy which staff could refer to if required.

However, staff were aware of the basic principles of the Act and always assumed a client had capacity. Mental capacity can be temporarily impaired in those clients recently using illicit substances. Staff provided examples of clients sometimes attending whilst being intoxicated. If a client attended the service intoxicated or under the influence of substances, staff would postpone any decisions until they regained capacity. Staff discussed clients' capacity with clinicians and their manager if the need arose.

Lifeline reported that most clients did not have cognitive impairments that would mean they could not consent to care or treatment. We observed staff discussing consent to treatment during their assessment. The consent to treatment, consent to share information and confidentiality agreement paperwork was complete and present in all 12 client records we looked at. It included sharing information with family members, other organisations and the national drug treatment monitoring system. It also included advice on the requirements of clients to notify the driver and vehicle licensing authority under the governments assessing fitness to drive guidance.

Equality and human rights

Lifeline set out their equality and human rights responsibilities in a number of policies, including their equal opportunities policy, employee handbook and training and development policy. Lifeline is an equal opportunities employer and had undertaken equality impact assessments.

The organisation had recently introduced equality and diversity e-learning training. At the time of inspection, no staff had completed this. However, we did see reference to equality and diversity discussion in team meeting minutes.

Information received prior to and during inspection did not give us any cause for concern that protective characteristics were discriminated against during the recruitment of staff, staff engagement and client treatment.

Management of transition arrangements, referral and discharge

Lifeline in Hull formed part of the treatment system under the ReNew umbrella commissioned by Hull City Council. Staff planned client transition arrangements between different provisions in the system following agreed pathways. This meant that a client's treatment journey was seamless and without breaks.

For clients referred from elsewhere or to another service not in the Hull area, staff planned the transfer on an individual basis liaising with the previous or new provider.

The Lifeline service included staff specifically working in through-care and aftercare to ensure effective transitions and discharge arrangements.

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Are substance misuse services caring?

Kindness, dignity, respect and support

Staff showed a caring and supportive attitude to clients. They were sensitive to their needs and showed a good understanding of the issues they faced. We observed staff interacting with kindness and patience during client appointments and groups. Staff spoke about clients in a respectful manner. All clients we spoke with felt staff listened to them and treated them with dignity and a non-judgemental approach.

Staff respected confidentiality. There were clear information sharing agreements in place between the client and the service. Clients signed consent forms specific to each agency or person with whom the client agreed to share information. Clients could withhold their consent and staff respected their wishes.

The involvement of clients in the care they receive

Staff involved clients in the care they received. They discussed treatment options with them during assessment, one to one sessions and in groups. Recovery plans contained personalised goals and encouragement to progress in their own recovery journey. Staff explored strengths with the clients and identified areas for development to make progress achievable.

Clients told us that they received copies of their recovery plans. However, this was not always accurately documented in the records. For example, three of the 12 records we looked at did not state whether the client had received a copy of their care plan.

The family team offered appropriate involvement and support to families. This included parenting courses, counselling for children of clients, information around treatments and groups for support. The team supported to increase the clients motivation for change.

Services had information leaflets relating to conditions, medications advocacy services and support groups. These were accessible to both clients and their families.

Clients had opportunities to feedback on the care they received through one to one sessions and using comment boxes that were available in the reception area of each location. The organisation invited clients to participate in a Lifeline opinion poll that rated the environment,

information, involvement, listening, respect and timeliness. In the latest poll, clients from Lifeline Hull rated the service above four out of five in all areas. However, the service only received responses from nine clients.

Are substance misuse services responsive to people's needs? (for example, to feedback?)

Access and discharge

Referrals into the service came through a single point of contact from GPs, other organisations and self-referrals. The service did not take clients involved in the criminal justice process; another organisation in the ReNew treatment system supported these clients.

For the period 1 April 2016 to 30 September 2016, the service received 341 new referrals. Of these, 72 were clients experiencing difficulties with alcohol and other non-opiate substances, 139 with alcohol alone difficulties, 27 with non-opiate only difficulties and 103 with opiate use.

From referral, clients waited an average of two weeks for their assessment and commencement of treatment. The national target, from Public Health England, is for clients to receive their first treatment interventions within three weeks from referral. Staff prioritised clients deemed as more urgent due to their risks.

Following an audit, the service had identified improvements they could implement to maintain clients in treatment who were showing signs of disengagement. Managers had recently introduced a pro-active engagement pathway. The aim of this was to outline actions staff were required to take to actively maintain a client within the treatment service and prevent unplanned discharges. Staff liaised with pharmacies, other involved organisations, made calls and contacted clients by letter prior to making the decision to discharge.

As agreed within individual information sharing agreements, staff informed the other agencies working with the client if the service discharged them due to non-engagement. Staff discussed any high-risk clients during clinical meetings. We observed a discussion regarding the recent dis-engagement of a client with young children in the clinical meeting. Staff considered approaches they could take to encourage the client back

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into the service, which would therefore provide support and protective factors for the children. They also considered the steps they would need to take if re-engagement did not occur.

Team leaders were responsible for auditing all unplanned client discharges. This was to ensure that staff had made every effort to engage the client and had followed the correct procedures.

The service had a key performance indicator to successfully discharge clients from the service. A client is deemed as successfully discharged if they no longer required clinical or structured treatment and were substance free. Latest figures showed the service had discharged 356 clients between 1 April 2016 and 30 September 2016. Of these, the service successfully discharged 213 clients, 109 clients left the service in an unplanned way and staff transferred 34 clients onto custody or other providers.

The service gave clients flexibility in appointment times. The three locations meant that clients did not need to travel too far. Each location offered late night appointments. Staff from the family team offered alternative venues for appointments if this were required. Clients remained in service for varying lengths of time depending on their personal circumstances. Staff told us they did not discharge clients unless they had addressed risks and reduced the possibilities of relapse as much as possible. On occasions, clients returned to the service following discharge. This occurred for both clients successfully discharged or for those who disengaged. Staff recognised the client's vulnerability and accepted all clients back into treatment without imposing any restrictions or above normal waiting times.

The facilities promote recovery, comfort, dignity and confidentiality

All locations were situated within community services, for example, shops and community centres. This promoted social inclusion for clients. Each location had a relaxed atmosphere with good quality furnishings. Client waiting areas were clean, tidy and welcoming with water available.

Rooms for client appointments were private. However, staff told us that it was sometimes difficult to find an available room at the Octagon. They also told us, and we observed,

that most of the rooms at the Octagon did not have external windows and that the air conditioning often did not work correctly. This meant it was not always a comfortable environment in which to promote recovery.

The service offered a range of recovery focused activities and were expanding this programme at the time of our inspection. Most of these activities took place at the Octagon but clients from both Bransholme and Gypsyville could attend. Activities offered ranged from diversionary activities to therapeutic groups. These included singing, mindfulness, mutual aid groups and substance specific groups, for example a group for cannabis users. The Octagon also held a breakfast club each morning. Clients could drop in for tea, toast and an informal chat with peers and volunteers for additional support as required.

All the locations displayed posters or had information leaflets relating to support groups, promoting recovery, information on how to complain and information on treatments.

Meeting the needs of all clients

All services were accessible for clients using wheelchairs. Bransholme and Gypsyville were ground floor buildings. The Octagon was located on a higher level with available lifts for access.

Each location had toilets accessible to clients using wheelchairs.

Lifeline used an interpreter service where this was required and staff could request literature in different languages as needed.

Clients were able to choose the service location they visited; this was not dependant on the area they lived. Some clients preferred to use the Octagon, as it was centrally located.

Staff from the service aimed to meet the needs of the local population. They joined meetings with black and ethnic minority groups, the deaf population and the lesbian, gay, bi-sexual and transgender population. The service provided a regular promotion slot on the local lesbian, gay, bi-sexual and transgender radio station. They also hosted an event for older people focussing on alcohol and drug awareness.

The service took steps to engage with client groups who generally have difficulties in attending services. They

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regularly visited the local hostels to encourage the homeless population into treatment. Staff also accompanied other services on evenings distributing service leaflets within the city to people who may benefit from the service, for example, street drinkers.

Listening to and learning from concerns and complaints

The operational manager had the day to day responsibility for managing and reporting complaints. All complaints were submitted centrally to Lifeline's clinical governance team.

Complaints were a standing agenda item at the organisation's board meeting where trends were considered. The organisation's complaints policy aimed to resolve complaints as quickly as possible and at service level. However, the policy stated staff should report any resolved complaint and their actions for organisational learning.

All locations had posters displayed informing clients how to complain. Staff also provided a verbal explanation of the complaints procedure at initial assessment and again if a client raised any concerns about the services throughout their treatment journey.

The service received three formal complaints in the 12 months prior to our inspection. Managers carried out investigations of all three. The service upheld one of the complaints. This related to a client who felt staff had not effectively communicated treatment options regarding detoxification.

Are substance misuse services well-led?

Vision and values

Lifeline's mission statement was to work with individuals, families and communities to both prevent and reduce harm, to promote recovery, and to challenge the inequalities linked to drug and alcohol misuse. Their vision was to provide alcohol and drug services that they were proud of; services that value people and achieve change. A list of four values focussed on improving lives, effective engagement, exceeding expectations and maintaining integrity.

The Lifeline service in Hull was also included under the Hull City Council's treatment system ReNew. ReNew's mission

was to work with whole families and individuals to reduce the impact of substance misuse, to support recovery and to challenge inequalities linked to drugs and alcohol. Their vision was to provide a confidential and friendly drug service to be proud of and a service that values families and their achievements and supports change.

Staff were aware of both sets of values and felt that the service integrated them into team meetings, supervisions and appraisals.

Staff knew who the senior managers of the organisation were. This was mainly due to recent management changes within the service, which resulted in a greater presence from higher managers in the organisation.

Good governance

Managers from the Hull service had systems and processes in place that were effective in ensuring:

- Staff levels were sufficient for clients to be seen regularly.
- Incidents were recorded and investigated.
- Staff followed safeguarding procedures.
- Complaints were recorded and investigated.
- Staff participated in clinical audits.

However, the service did not have an effective system in place to monitor training. Managers were unable to define the training staff were required to do as mandatory, the regularity of the training and what they expected in terms of compliance. This meant managers did not have a clear oversight to assure them of staff competency.

The service had a system to ensure staff received regular supervision and a yearly appraisal. However, the effectiveness of the supervisions and appraisals were compromised due to unclear training requirements

Managers reported information relating to incidents, service risks, performance and complaints to the organisations governance committee, which then reported to Lifeline's executive board. A team of administrators supported them.

Policies were up to date and in line with new legislation and guidance. The management team attended regular meetings with commissioners to discuss key performance indicators and the service level agreements. They also submitted monthly and quarterly reports.

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The manager was able to submit items to the organisation's risk register. The most recent risk register, dated June 2016, highlighted the Hull service as high risk due to uncertainties in future funding levels.

Leadership, morale and staff engagement

Lifeline Hull had experienced a period of management uncertainty in the months prior to our inspection. At the time of inspecting, the organisation was recruiting for a new service manager. A senior manager from within the organisation was overseeing the service in the interim period. Staff told us that the management issues had been unsettling and there had been a lack of clarity in the leadership due to changes. However, most reported recent improvements with morale increasing across the teams. Staff mostly felt supported by both managers and peers and enjoyed the work they carried out.

However, three staff we spoke to from the Octagon, reported stress relating to the environment they worked in. Staff did not have permanent desk space and informed us

that access to a computer and desk was sometimes limited. They also informed us that their office space was not conducive to effective working due to having no natural light, fresh air and limited space.

Staff knew the whistleblowing process and said they would be able to raise concerns if the need arose without fear of victimisation. The teams had no bullying or harassment cases at the time of our inspection.

Lifeline had invested in leadership training for the Hull team. Twenty staff from Hull had completed an internal leadership programme.

Commitment to quality improvement and innovation

Staff felt able to contribute to quality improvements through discussions in team meetings and supervisions.

The service was not involved in any national innovations or quality improvement programmes at the time of our inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must implement improved systems to review and monitor training requirements and ensure staff training compliance is improved.

Action the provider **SHOULD** take to improve

- The provider should ensure staff remain up to date in the knowledge and delivery of psychosocial interventions.
- The provider should ensure recovery plans reflect identified needs.
- The provider should ensure staff fully explore a client's physical health needs.
- The provider should ensure staff and clients have adequate space at the Octagon which should be well ventilated.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 18 HSCA (RA) Regulations 2014 Staffing</p> <p>Regulation 18 Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe Staffing</p> <p>How this regulation was not being met:</p> <ul style="list-style-type: none">• The service did not specify which training units staff were required to complete or how often. Training compliance was generally low in many of their units. This meant they were unable to assess, monitor and improve the quality and safety of the service provided. <p>This was a breach of regulation 18 (2) (a)</p>